52. *Reduction of Dislocation of the Shoulder.*—M. Revillout gives an account of the mode which M. Panas adopts for the easy accomplishment of this. M. Panas believes that almost all these dislocations are produced by a rotation of the humerus; and as the result of numerous experiments he found that it is very easy to lacerate by a movement of rotation a capsular ligament which would resist a direct traction of 600 kilogrammes. Generally, also, the tendon of the subscapularis is ruptured in the dislocation forwards. For the easy reduction of this dislocation it is of importance to keep the arm rotated outwards. For, in fact, once beyond the button-hole laceration of the capsule, the head of the bone, when carried inwards, lies supported on the inner lip of the laceration ; so that if reduction be attempted in this position, the head being separated from the glenoid cavity by a more or less broad ligamentous bridle, it cannot succeed unless by rupturing this bridle, which it is not always easy to do. When, however, muscular resistance having been overcome by a sufficient extension sufficiently prolonged, the head of the bone is brought by rotation outwards to the middle of the rupture, it suffices to push it with the hand to effect reduction—if it has not become self-adjusted without any noise. Preparatory to this movement of rotation, M. Panas causes traction to be made at the arm above the elbow, instead of at the wrist. In this way the flexed forearm is in readiness to be carried outwards at the appropriate moment. Much force is not required for extension, provided the muscular relaxation is patiently waited for. M. Panas has succeeded in this manner in somewhat old dislocations, providing a sufficient time had not elapsed to give rise to an altered formation of the articular cavity.—*Med. Times and Gaz.*, Aug. 21, 1875, from *Gazette des Hôpitaux*, July 31, 1875.

53. *Value of Fluctuation as a Sign.*—Mr. T. H. Bartlett, in a short paper (*Brit. and For. Med. Chirurg. Rev.*, July, 1875), considers this subject. All surgeons are aware how often they are deceived with regard to apparent fluctuation being pathognomonic of the presence of fluid. He says, "there must be some peculiar or ill-understood or ill-recognized condition which led many skilful and careful men into error, and which are constantly leading our students into similar mistakes.

"I believe this false fluctuation to be generally due to the combination of two causes of error, one being muscular or glandular elasticity, and the other being muscular or glandular displacement.

"I think any one who tries the experiment will be surprised at the sensation of fluctuation which can be obtained by pressing alternately, as in endeavouring to find the sense of elasticity or fluctuation of an abscess, a muscle across the direction of its fibres, say the biceps, or by similarly manipulating across the direction of the ducts, a firm and fairly large female mamma ; either one of these two before-mentioned causes alone might mislead : I mean either the displacement of the gland or muscle or the elasticity of the gland or muscle : but when you get combined the elasticity and the displacement, a supposititious fluctuation is felt so like to the real as to be almost if not quite undistinguishable from it. How, then, are we to be certain, especially in these positions, where either a gland or muscle is liable to mislead us, that the fluctuation we feel is really due to fluid ? By a very simple plan, which I have never known to fail, and which is not clearly enunciated to my knowledge in any of our text-books, viz. by practising the manœuvre of palpation, not only across the line of the muscular fibres or of the gland ducts, but also in a direction at right angles to this.

"If the fluctuation be fluid it will be equally felt in all directions ; if it be due to muscular or glandular elasticity or displacement, or both combined, it will be only felt in one direction, viz. across the muscular fibres or the gland ducts."

54. *Electrolysis in certain forms of Vascular Erectile Tumours.*—Prof. Spence regards this as a most valuable addition to our means of treatment of these often formidable growths. "I do not speak of it," he remarks in his Address in Surgery before the British Medical Association, "as a general method, for there are many forms of nævi and erectile tumours, in truth a

majority of that class of diseases, in which other methods are more rapidly effective.

"Galvano-puncture is specially indicated in those cases in which the erectile tumour is deep-seated and covered by healthy undiscoloured skin. Until a few years ago, our interference in such cases was limited to dissecting off and reflecting the superimposed textures, so as to expose the tumour without touching it with the knife, and then strangulating it by strong ligatures, and, when the growth has sloughed and separated, replacing the flaps of skin; or by ligature of large arterial trunks indirectly connected with the growth—as, for example, ligature of the carotid artery for orbital erectile growths. The former method was attended with grave inconveniences and dangers, and the latter, besides entailing risk, was most uncertain in its effects, as you can readily understand from the nature of the disease. More recently, injections with the perchloride of iron took the place of these methods, and, in a great number of cases, answered very well, but in others a very considerable amount of sloughing took place before the rest of the tumour had been consolidated, and in such cases severe hemorrhage occurred, and the life of the patient was endangered. In some cases also the injections of perchloride were attended with a rapidly fatal issue, apparently from thrombosis. I must, however, say that I never saw such a result, though I have long used and continue to use the perchloride of iron injections, and I can only attribute such accidents to the neglect of tearing up the texture of the tumour before injecting the perchloride.

"*Contrast* of the results of different methods is perhaps the most effectual way of impressing their comparative advantages, and shows what advance our science is making; let me, therefore, bring under your notice the following cases from my own practice. An infant, six weeks old, was sent to my care on account of a deep-seated pulsating erectile tumour, occupying the palm of the hand, and extending up the wrist. The tumour had been growing rapidly, and at one point the skin was thin and discoloured. I used injection of perchloride of iron, and part consolidated. Again it was used, and the consolidation was followed by inflammation and the separation of a small central slough. From the ulcerated surface bleeding took place, and, though arrested by local application of the perchloride, it returned from time to time; and as the child's life was thus endangered, and the growth seemed rather to increase than diminish, I was forced to amputate in the forearm, when the infant was eight weeks old. She made a very rapid recovery, but with the loss of a hand. I show you here the cast of the hand of an infant affected with deep-seated pulsating erectile tumour very similar to the former. In this case I applied electrolysis during three months, while the child was under my care in hospital, and by several applications of the battery the growth began to consolidate and contract, whilst, except at the time of an application, the child suffered no irritation. As it was inconvenient for the mother to remain in hospital, I asked Dr. Connell, of Peebles, who had sent the case to me, to conduct the remainder of the treatment. As the child's parents lived at some distance from Peebles, the application of electrolysis could only be made at long and irregular intervals. Here is a cast of the hand when the cure was completed; and, when you contrast it with this preparation of the amputated hand of my former case, you will, I think, agree with me that the result is a triumphant vindication of the value of electrolysis in such cases. I have used it also in other cases with advantage, especially in an enormous erectile nævus of the face of a girl. It is of importance that it should not be applied indiscriminately to all cases of nævus or erectile tumours. I think its use should be restricted to cases where the erectile growth is covered to some depth by healthy skin. The needles are coated to a certain length with a non-conducting material, which protects the healthy superimposed texture, whilst the uncovered points passed into the growth act on it at different parts. If needles be applied to a superficial erectile spot, they cauterize and leave more mark than other methods, such as application of nitric acid, perchloride of iron, or iodine. Thus, in treating the large erectile nævus of the face, the electrolysis was only used to the deep-seated portions, while the superficial discoloured marks were treated by applications of perchloride, iodine, etc."—*British Med. Journ.*, Aug. 14, 1875.

55. *Operations on the Air-passages.*—Prof. SPENCE, in his recent address on the Progress of Surgery, calls attention to some practical points connected with these operations. "There are," he says, "some conditions not sufficiently insisted on in surgical works as to their dangers, or the practice to be adopted, where action requires to be prompt. Thus the danger from emphysema of the loose connective tissue of the neck is seldom adverted to; and yet I have seen a patient all but suffocated from this cause from a small oblique wound of the larynx inflicted with a penknife. In that case, I had to perform laryngotomy, and was obliged to make numerous incisions to afford relief; when a simple enlargement of the wound, in the first instance, would have allowed the air to escape externally. Again, in tracheotomy for removal of foreign bodies, it is generally considered unnecessary to use a tube after the foreign body has been expelled, but merely to allow the incision to close at once. The consequence is that a good deal of trouble often results, for the wounds in the trachea and the superimposed parts do not correspond, and air and mucus escape into the cellular tissue, sometimes giving rise to considerable emphysematous swelling of the neck, and often leading to deep-seated irritation of the wound. In my own operations after removal of foreign bodies, I insert a tracheotomy tube, and retain it until the surface of the wound is glazed by the effusion of lymph; and then approximate the margins of the wound by strips of plaster, so as to avoid all risk of confinement of air or mucus in the tissues in the vicinity of the trachea. Another point of importance is the question of exhibiting anæsthetics in operations for removal of foreign bodies. Many years ago, I drew attention to this, and pointed out that when the foreign body was loose in the trachea or bronchus, the exhibition of anæsthetics interfered with the force of the expulsive powers which usually eject the foreign substance; and, as happened in one of my own cases, the foreign body may be carried back by the incoming current of air, occlude the bronchus, and cause collapse of the corresponding lung. In other cases, as when the body is impacted in the bronchus or larynx, anæsthetics are most useful in enabling us to search for and remove the foreign substance. In doubtful cases, the rule should be to open the trachea without using anæsthetics; and, if the foreign body be not expelled by the natural forces, then to administer chloroform to enable us to deal with it effectually. When, as in the case I have alluded to, a foreign body, such as a plum-stone, is impacted, and fairly occludes the bronchus, being carried before the inspired air, it follows that, the lung beyond being collapsed, there is no force behind to eject the substance. In such circumstances, it is well to avoid trying too much to displace it by means of bent probes or other instruments, unless the end of the instrument can be passed over and beyond the body, so as to tilt it out or allow air to pass to the lung beyond. Our continued efforts, besides exciting local irritability, are very likely to impact it more thoroughly; and I would therefore counsel the surgeon to abstain from useless efforts, and allow the patient to breathe by the sound lung, and wait the loosening of the foreign body by vital dilatation caused by its presence, when air will gradually pass beyond and expel it.

"In hollow or tubular foreign bodies, the case is different; they can be easily removed if we take the proper method—one which I practised some thirteen years ago, in a case where this trachea-tube had slipped down and became impacted in the left bronchus. Instead of trying to open the forceps and seize the edges of the tube, I passed the forceps closed into the tube, and then, on expanding the blades and maintaining them expanded, the foreign body was withdrawn with the utmost facility."—*British. Med. Journ.*, Aug. 14, 1875.

56. *Total Excision of the Larynx.*—On July 21 last, Prof. VON LANGENBECK, of Berlin, performed the above operation on a man aged fifty-seven, with cancerous infiltration of the whole upper portion of the larynx above the ventricles, involving also the epiglottis and the hyoid bone, as well as the base of the